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Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

DEERE & COMPANY,
Petitioner,

vs.

T. J. KENNEDY, *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE ILLINOIS SUPREME COURT

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QUESTION PRESENTED FOR REVIEW

Whether the Illinois Supreme Court properly applied the common law of assignments to expand the civil enforcement provisions of ERISA, which are literally available only to a "participant" or "beneficiary" of an employee benefit plan, thereby enabling a health care provider (chiropractor) who has obtained an assignment from an employee-patient to avail himself of ERISA's extraordinary remedies, directly against his patient's employer.

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings below were the petitioner Deere & Company and the respondents T. J. Kennedy, D.C.; Terry L. Burke d/b/a Burke Chiropractic Clinic; Michael H. W. Hurst d/b/a Hurst Chiropractic Center; Stephen Miner, D.C. d/b/a Miner Chiropractic Clinic; and James P. Woods, D.C. In the trial court the suit of Harlow E. Wells, D.C. had been consolidated with the suits of the other respondents named above, but Wells voluntarily dismissed his suit against the petitioner on November 16, 1984.

The petitioner Deere & Company is a publicly held company which has no parent company or affiliates. Its subsidiaries (other than wholly owned subsidiaries) are:

1. (United States) Bunton Company; Amerequip Corporation; Agro Systems Corporation; Vectron, Inc.; and Detroit Deere Corporation.

2. (Foreign) John Deere S.A. de C.V. (Mexico); Yanmar-John Deere Engineering Yugen Kaisha (Japan); FANATRACTO (Fabrica Nacional de Tractores y Motores S.A.) (Venezuela); Chamberlain Holdings Limited (Australia); SLC S.A. Industria e Comercio (Brazil); John Deere Lanz Verwaltungs A.G. (Germany); ADELA Investment Company S.A. (Luxembourg); and LAAD S.A. (Panama).

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PETITION FOR A WRIT OF CERTIORARI TO THE ILLINOIS SUPREME COURT

The petitioner Deere & Company respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Illinois Supreme Court, entered in the above-entitled proceeding on September 21, 1987.

OPINIONS BELOW

The opinion of the Illinois Supreme Court is reported at 118 Ill.2d 69, 514 N.E.2d 171. It appears at p. A-1 of the appendix ("App.").

The opinion of the Appellate Court of Illinois, Third District, is reported at 142 Ill.App.3d 781, 492 N.E.2d 199, and appears at App. A-8.

The order of the trial court dismissing the respondents' complaints for lack of standing to sue under the Employee Retire-

ment Income Security Act of 1974 [29 U.S.C. sec. 1001 et seq. (ERISA)], appears at App. A-17.

JURISDICTION

In their complaints as finally amended the respondents asserted causes of action under ERISA only, stating that they are "beneficiaries" as defined in sec. 3(8) of ERISA [29 U.S.C. sec. 1002(8)] and claim that as such they are entitled to file an action under sec. 502(a)(1) [29 U.S.C. sec. 1132(a)(1)] against the employer of their patients for benefits claimed to be due under a health benefit plan. By virtue of ERISA sec. 502(e)(1) [29 U.S.C. sec. 1132(e)(1)], state courts are given concurrent jurisdiction of such actions with district courts of the United States.

On March 19, 1985 the trial court sustained petitioner's motions to dismiss, and dismissed the complaints with prejudice for lack of standing to sue under ERISA. See App. A-17.

On respondents' appeals, the Appellate Court of Illinois for the Third District entered a judgment and opinion reversing the Circuit Court of Rock Island County, holding that respondents had status to sue under ERISA. See App. A-8. Petition for rehearing was denied on May 19, 1986.

The Illinois Supreme Court granted the petitioner leave to appeal. On September 21, 1987 the Illinois Supreme Court entered a judgment and opinion affirming the decision of the Appellate Court and remanding the case to the trial court for further proceedings. See App. A-1. No petition for rehearing was sought.

The jurisdiction of this Court to review the judgment of the Illinois Supreme Court is invoked under 28 U.S.C. sec. 1257(3). Although there may be further proceedings in the trial court, there has been in this case a final determination of the federal issue by the Illinois Supreme Court which affords jurisdiction at

this time by this Court under the standards set forth in *Cox Broadcasting Corporation v. Cohn,* 420 U.S. 469 (1975).

STATUTES INVOLVED

Sec. 502(a)(1)(B) of ERISA [29 U.S.C. sec. 1132(a)(1)(B)]:

A civil action may be brought —

(1) by a participant or beneficiary * * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan ***

[The full text of sec. 502(a) appears at App. A-20 and A-21.]

STATEMENT OF THE CASE

The petitioner Deere & Company ("Deere") provides a wide variety of health benefits to its many employees and their dependents including a collectively bargained health benefit plan (the "plan"), administered by Deere as named fiduciary and plan administrator, which reimburses the employees for medical care provided to them, including the reasonable and customary cost of services given by chiropractors. The plan permits payment of amounts allowable under the plan to be made directly to the health provider if the employee signs an authorization to pay form.

Under this procedure, a dispute arose when the respondent chiropractors asserted that the value of their services rendered to petitioner's employees and their dependents far exceeded the amounts allowed for such services under the plan. This litigation commenced when the five respondents brought suit separately against petitioner in the Circuit Court of Rock Island County, Illinois for total sums in excess of $940,000 over and above the amounts already allowed and previously paid to them by petitioner pursuant to such payment authorizations.

This case does not involve, as might be inferred from the opinion of the Illinois Supreme Court, only "several" of petitioner's employees. It is obvious from the amounts claimed that a large number of employees are involved. Nor does the case involve outright refusal by petitioner to pay the plan's benefits, as also might be inferred from a reading of that opinion. Exhibits attached to the complaints show that in every instance, payments were in fact made except for that portion of the charges "in excess of the maximum allowable fee." [e.g., see Exhibit "E" to Kennedy complaint, R. (83 L 230), C-270, 272]. Instead, the case finds its genesis in a sharp disagreement between petitioner and respondents as to whether respondents were overcharging for their services.

The initial 1983 complaints were for alleged breach of contract under state law, based upon such patient authorizations (and upon additional assignment forms prepared by the chiropractors and signed by patients), and also for alleged violations of the Illinois Insurance Code. Each of these complaints was challenged by an identical motion to dismiss filed by petitioner asserting that its plan was protected by the preemption provisions of ERISA (The Employee Retirement Income Security Act of 1974, 29 U.S.C. sec. 1001 et seq.), which superseded state law. The motions were allowed and all complaints dismissed.

Unable to avoid the preemption defense under sec. 514(a) of ERISA [29 U.S.C. 1144(a)], respondents eventually abandoned all state law claims, and on December 3, 1984 all complaints were amended to their final form. In each, the respondents assert causes of action solely under ERISA, claiming "beneficiary" status under sec. 3(8) [29 U.S.C. sec. 1002(8)] which they say entitles them to sue petitioner directly under the civil enforcement provisions of ERISA. These provisions authorize a "participant" or "beneficiary" to bring a civil action in federal or state court "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms

of the plan, or to clarify his rights to future benefits under the terms of the plan *** .'' [ERISA sec. 502(a)(1)(B), 29 U.S.C. sec. 1132(a)(1)(B)]. The final amended complaints may be found at R. (83 L 120), C-265 (Kennedy), C-277 (Burke), C-285 (Hurst), C-294 (Miner), and C-306 (Woods).

Motions to dismiss all amended complaints, challenging respondents' status under ERISA to sue as ''beneficiaries'' were allowed by the trial court, and all complaints were dismissed with prejudice on this ground. App. A-17.

Upon appeal by respondents the appellate court reversed, holding that any health provider who possesses a patient assignment ''has standing to sue as the 'participant' or 'beneficiary' in whose shoes he stands for purposes of sec. 1132(a)(1)(B).'' 142 Ill.App.3d 781, 492 N.E.2d 199 at 203 (App. A-16).

Petitioner filed a petition for leave to appeal to the Illinois Supreme Court, and it was after this petition was filed that *Misic v. Building Services Employees Health & Welfare Trust,* 789 F.2d 1374 (9th Cir. 1986) was published. Although the Illinois Supreme Court granted leave to appeal after it was made aware of *Misic,* it relied on *Misic* in affirming the appellate court. *Misic,* in common with the appellate court, declared that a health provider (dentist) could sue under ERISA, but found it unnecessary to characterize the health provider as a ''beneficiary''; an assignment from the patient was found to be entirely sufficient:

> These arguments mistakenly treat Dr. Misic as a suitor in his own right. Dr. Misic sues derivatively, as assignee of beneficiaries.

Id., at 1378. The Illinois Supreme Court, however, also characterized the respondents as ''beneficiaries'' under ERISA; but agreed with *Misic* that, even so, nothing more than an assignment was necessary to authorize any assignee to sue.

REASONS FOR GRANTING THE WRIT

The Decision Of The Illinois Supreme Court, In Expanding The Category Of Persons Entitled To Sue Under Erisa, Ignores The Plain Language Of The Statute, Which Carefully Enumerates And Limits The Parties Entitled To Seek Relief Under Its Civil Enforcement Provisions; Conflicts With Decisions Of This Court And Other Federal Courts Which Have Refused To Expand The Availability Of Erisa Remedies; Fails To Follow Established Principles Of Statutory Interpretation; Adversely Affects Thousands Of Employee Benefit Plans Throughout The Nation; And Seriously Erodes The Declared Federal Policy Of Encouraging The Formation, Continuance And Growth Of Such Plans.

The public policy encourages the formation and maintenance of employee benefit plans by the nation's employers.[1] The decision of the Illinois Supreme Court would now add the cost of defense of suits in federal and state courts by health providers, for ordinary services rendered, to the already heavy burden of those employers who maintain such plans.

Petitioner submits that Congress never intended such a result.

By imposing such an unwarranted additional burden, the decision not only discourages that public policy but also runs contrary to the guidance for interpretation of ERISA's civil enforcement provisions provided by three recent decisions of this Court.

---

[1] At the time of enactment of ERISA, Congress found:

> ** that the continued well-being and security of millions of employees and their dependents are directly affected by (employee benefit) plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations ** . Sec. 2(a) of ERISA [29 U.S.C. sec. 1001(a)].

In April of this year this Court observed that in the civil enforcement area, ERISA involves "a careful and deliberate balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life Insurance Company v. Dedeaux,* ____ U.S. ____, 107 S.Ct. 1549, 1556 (1987). The Court stated:

> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

Id., at 1556, 1557.

In *Massachusetts Mutual Life Insurance Company v. Russell,* 473 U.S. 134, 105 S.Ct. 3085 (1985), this Court declined to find an implied cause of action under ERISA for punitive damages against the plan fiduciary for untimely processing of a benefit claim. The Court stated:

> The six carefully-integrated civil enforcement provisions found in sec. 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme which is in turn part of a "comprehensive and reticulated statute." *Nachman Corp. v. Pension Benefit Guaranty Corp.,* 446 U.S. 359, 361 (1980). (emphasis by the court)
>
> * * *
>
> We are reluctant to "fine-tune" an enforcement scheme crafted with such evident care as the one in ERISA. As we stated in *Transamerica Mortgage Advisors, Inc. v. Lewis*

> (TAMA), 444 U.S. 11, 19, 100 S.Ct. 242, 246, 62 L.Ed.2d 146 (1979): "[W]here a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it." See also *Touche Ross & Co., v. Redington,* 442 U.S. 560, 571-574, 99 S.Ct. 2479, 2486-2488, 61 L.Ed.2d 82 (1979). "The presumption that a remedy was deliberately omitted from a statute is strongest when Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement." *Northwest Airlines, Inc. v. Transport Workers Union,* 451 U.S., at 97.

Id., 105 S.Ct. at 3093.

This reluctance to tamper with ERISA's integrated enforcement scheme in order to find *remedies* not set forth in the statute has also been applied in discussing the rights of *parties* not expressly named in ERISA. In *Franchise Tax Board of the State of California v. Construction Laborers Vacation Trust for Southern California,* 463 U.S. 1, 103 S.Ct. 2840 (1983), this Court stated:

* * *

> The express grant of federal jurisdiction in ERISA is limited to suits brought by certain parties, see *infra,* at 2854, as to whom Congress presumably determined that a right to enter federal court was necessary to further the statute's purposes.

* * *

> The phrasing of sec. 502(a) is instructive. Section 502(a) specifies which persons — participants, beneficiaries, fiduciaries, or the Secretary of Labor — may bring actions for particular kinds of relief.

* * *

> ERISA carefully enumerates the parties entitled to seek relief under sec. 502; it does not provide anyone other than participants, beneficiaries, or fiduciaries with an express cause of action for a declaratory judgment on the issues in this case. A suit for similar relief by some other party does not "arise under" that provision.

Id., 103 S.Ct. at 2852, 2854 and 2855.

A number of other cases conform to the limitations suggested in *Franchise Tax Board.* A variety of suitors claiming implicit "participant" or "beneficiary" status have been denied standing to sue under ERISA. *See, National Bank of North America v. Local 533 Pension Fund of the International Brotherhood of Teamsters and Chauffeurs,* 463 F.Supp.. 636 (E.D. N.Y. 1978) (judgment creditor); *Tuvia Convalescent Home v. National Union of Hospital and Health Care Employees,* 717 F.2d 726 (2nd Cir. 1983) (employer); *Hibernia Bank v. International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America,* 411 F.Supp. 748 (N.D. Cal. 1976) (bank); and *R. M. Bowler Contract Hauling Co., Inc. v. Central States, Southeast and Southwest Areas Pension Fund,* 547 F.Supp. 783 (S.D. Ill. 1982) (employer).

By failing to heed the decisions of this Court limiting both remedies and parties to those expressly named in ERISA, the Illinois Supreme Court has erroneously added a new category of persons supposedly protected by ERISA — the assignee. In doing so, the Court relied primarily upon *Misic, supra,* 789 F.2d 1374.

This reliance is misplaced, however, because *Misic,* although clearly in point, also failed to defer to the teaching of *Franchise Tax Board, Russell* and *Dedeaux.* The Ninth Circuit in *Misic,* and now the Illinois Supreme Court, stand alone as authority that an assignee may sue under ERISA, supported by neither precedent nor logic.

Before deciding *Misic*, the Ninth Circuit, recognizing the rule that the "*amicus curiae* position of an agency charged with the principal enforcement of an act should be carefully considered," requested the Department of Labor to file a brief. *Id.*, n. 2, 789 F.2d at 1377.

In that brief, theSecretary of Labor came down squarely against granting an assignee status to sue, stating that in his opinion although ERISA does not preclude a participant's assignment of health plan benefits to a health provider, the Secretary's reading of *Franchise Tax Board* and *Russell* required the conclusion that:

> ... any party who is not specifically identified in ERISA sec. 502 as a potential plaintiff, lacks statutory standing to sue under ERISA. Moreover, while Congress clearly intended through ERISA sec. 502 to make the federal courts available to plan participants and beneficiaries to secure rights, founded in the law of trusts, to prudent and faithful fiduciary conduct, there is no suggestion anywhere in the statute or its legislative history that Congress intended at the same time to create a federal forum for health care providers and others claiming payment for ordinary services rendered.

Amicus Curiae Brief of the Department of Labor at 11, *Misic v. Building Services Employees Health and Welfare Trust*, 789 F.2d 1374 (9th Cir.) (No. 84-5618).

It appears that the Third Circuit would disagree with *Misic*. In *Northeast Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund* (3rd Cir. 1985), 764 F.2d 147, that court stated that "We have serious doubts whether (an ERISA beneficiary under sec. 502) could assign along with her substantive rights her right to sue in federal court," and noted that "Congress simply made no provision in sec. 1132(a)(1)(B) for persons other than participants and beneficiaries to sue, *including persons purporting to sue on their behalf.*" (emphasis added) *Id.*, n. 6 at 154.

Misic commends the assignment of health care benefits by patients to health providers, pointing out that the practice is desirable in that it eliminates the necessity of the patient paying the bills and then having to await reimbursement. Petitioner does not disagree with this analysis. The complaints correctly allege that Deere does honor authorizations to pay health providers directly when so directed by its employees; petitioner's disagreement is with the conclusion that the authorization carries with it anything more than the right to receive whatever payment is due under the plan. The right to *receive* and the right to *sue* are two very different things..

Both *Misic* and the Illinois Supreme Court gave great weight to ERISA's failure to expressly prohibit the assignment of health care benefit payments, in contrast to the prohibition in ERISA sec. 206(d) [29 U.S.C. sec. 1056(d)] of the assignment of pension benefits. Both courts then focused upon the law of assignments and concluded that since an assignment of health benefit payments was not prohibited, Congress must necessarily have intended that a participant or beneficiary could confer upon the assignee the identical rights possessed by the assignor, including status to sue.

In looking only to the law of assignments for the answer to the question of standing to sue, both courts failed to observe the basic rule of statutory construction set forth by this Court in *Dedeaux, supra,* in which this Court stated that in interpreting ERISA, it must "look to the provisions of the whole law, and to its object and policy." 107 S.Ct. 1549, at 1555.

The inquiry therefore should have been whether, scrutinizing ERISA as a whole, was it the object and policy of the law to protect a health provider, one who is not covered by the terms of the plan, who has no intrinsic interest in the plan or its administration, who has no pension interest to protect or medical needs to be served, no employment relationship or kinship of any kind to the employer, employees or their dependents — one

who wants nothing more than to use the machinery of ERISA to collect his bills?

If the simple execution of an authorization to pay invests the health provider with all the rights of the patient, petitioner asks this Court to consider the incongruity of a health provider then possessing the bristling arsenal of weapons described by this Court in *Russell:*

> If in this case, for example, the plan administrator had adhered to his initial determination that (the employee) was not entitled to disability benefits under the plan, (the employee) would have had a panoply of remedial devices at her disposal. To recover the benefits due her, she could have filed an action pursuant to 502(a)(1)(B) to recover accrued benefits, to get declaratory relief that she is entitled to benefits under the provisions of the plan contract, and to enjoin the plan administrator from improperly refusing to pay benefits in the future. If the plan administrator's refusal to pay contractually-authorized benefits had been willful and part of a larger systematic breach of fiduciary obligations, (the employee) in this hypothetical could have asked for removal of the fiduciary pursuant to sections 502(a)(2) and 409. Finally, in answer to a possible concern that attorney's fees might present a barrier to maintenance of suits for small claims, thereby risking underenforcement of beneficiaries' statutory rights, it should be noted that ERISA authorizes the award of attorney's fees. See sec. 502(g), 88 Stat. 892, as amended, 29 U.S.C. sec. 1132(g)(1).

Id., 105 S.Ct. 3085, at 3093.

Petitioner submits that Congress could not have intended that a chiropractor should have the right under ERISA to seek an injunction to remove the fiduciary of his patient's health benefit plan, or to collect attorney fees. If he does not have these rights, he cannot have the selective right to use ERISA simply to collect his service bills.

If the law of assignments is the touchstone in the interpretation of ERISA, this reasoning taken to its logical conclusion would require the bizarre result that a common bill collector, through a subassignment from the health provider, would have standing to enter federal or state court, sue the plan administrator under ERISA, and collect his attorney fees as well.

Logic suffers from an interpretive approach which concedes that ERISA preempts a suit on the assignment under state law, thus protecting the employer—but at the same time holds that the statute welcomes a suit on the identical assignment, under ERISA itself, because the assignee "stands in the shoes of the beneficiary"—thus nullifying that protection. Petitioner submits that the answer is not to be found by simply holding that an assignee stands in the shoes of the assignor, because the same "shoes" were worn in the suit filed under state law, which ERISA preempted.

The concern of the Illinois Supreme Court that failure to accord the health provider standing to sue the employer would entirely deny him any remedy (App. 8a) is unfounded. He retains the legal right to enforce payment against the plan participant, and the participant retains the legal right to seek reimbursement from the plan. Indeed, the assignment forms prepared by the respondents each contain the provision, "I recognize that payment for services rendered by Doctor is due upon receipt of the services but that Doctor has agreed to accept this Assignment as an accommodation to me and that Doctor may revoke this Assignment at any time." *Exhibit C to Complaint,* R. (83 L 280) C-60.

The authorization to pay qualifies the health provider to receive the payments allowed by the plan, but need not and should not be read to permit him to meddle in the employer's relationship with its employees and their dependents, to litigate directly against the plan, or to participate in its interpretation and administration. These rights reside in the plan participant

and beneficiary, and are more than sufficiently potent, as noted in *Russell,* to protect them — the true objects of congressional concern — from any impropriety in claim handling by the plan administrator.

The Illinois Supreme Court's conclusion that the respondents are "beneficiaries"[2] within the meaning of ERISA also fails under the analysis required by *Dedeaux,* under which it is seen that the context in which the term "beneficiary" is used elsewhere in ERISA sharply refutes such a conclusion: sec. 2(a), 29 U.S.C. sec. 1001(a) (purposes of the statute); sec. 101(a), 29 U.S.C. sec. 1021(a) (information required to be furnished to beneficiaries); sec. 104(b)(3), 29 U.S.C. 1024(b)(3) (statement of rights); sec. 105(a), 29 U.S.C. sec. 1025(a) (statement of accrued benefits); and sec. 404(a)(1), 29 U.S.C. 1104(a)(1) (fiduciary obligations). These references require the inescapable conclusion that congressional concern in the passage of ERISA was directed toward employees and their dependents — typically those whom the employees would normally be expected to name as "beneficiaries" to receive pension or life insurance benefits, or to *receive* medical care — and not toward those who provide medical care to them.

Also supporting this analysis is *Cameron Manor, Inc. v. United Mine Workers of America,* 575 F.Supp. 1243 (W.D. Pa. 1983), which was relied upon by the trial judge in this case in dismissing the respondents' complaints, in which the Court stated:

> ** [T]here is no indication that Congress intended by this statute to insure that health care facilities be paid. While plaintiff may indeed be entitled to a "benefit" through operation of the plan — i.e., payment for services — we

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[2] Sec. 3(8) of ERISA [29 U.S.C. sec. 1002(8)] defines "beneficiary" as "a person designated by a participant, or by the terms of an employer benefit plan, who is or may become entitled to a benefit thereunder."

> conclude that the term as employed in the statute does not permit of a construction broad enough to include a provider of health services to participants.

Id., 575 F.Supp. at 1244, 1245.

The decision of the Illinois Supreme Court also disregards the obvious intent of Congress to make ERISA as cost effective as possible, as evidenced by the exemption of plans from state regulation through its preemption provisions, and also by the mandating of informal and inexpensive settlement of claims disputes under such plans.[3]

As required by ERISA, Deere includes claim resolution procedures in its plan, providing for informal, non-litigation review of the denial of benefits by the employee (Exhibit A to Complaint, R. (83 L 120) at C-76, C-98, and C-99). The clear intent of the law is to resolve claim disputes at the work place and not in the courts.

The following incisive comments were made about such procedures in *Taylor v. Bakery and Confectionary Union and Industry International Welfare Fund,* (E.D.N.C., 1978), 455 F.Supp. 816:

> *** Much like the labor grievance system, this claim/appeals mechanism is designed to reduce frivolous claims,

[3] Section 503 of ERISA provides: In accordance with regulations of the Secretary, every employee benefit plan shall — (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. 29 U.S.C. sec. 1133. The Secretary of Labor, pursuant to 29 U.S.C. sec. 1135, has promulgated extensive guidelines to implement these requirements.

promote the consistent treatment of claims, and create a non-adversarial method of claims settlement.

* * *

Tied to these inter-fund claims procedures was Congress' awareness of the potential costs of pension reform, and it sought to "strike a balance between providing meaningful reform and keeping costs within reasonable limits." *(1974) U.S. Code Cong. & Admin. News, pp. 4670, 4682.* Congress was particularly concerned with outlining a private insurance system that would operate efficiently, thereby increasing its acceptance and institution among American business. *U.S. Code News, supra.* If claimants were allowed to litigate the validity of their claims before a final (fiduciary) decision was rendered, the costs of dispute settlement would increase markedly for employers. ***.

Id., at 819, 820.

All ERISA plans require a dissatisfied employee to deal directly with the plan administrator in appealing health benefit claim denials or resolving disputes of interpretation. The plan administrator is not expected or required to deal with an employee's health provider in these informal procedures. All Deere employees and dependents who are patients of the respondents are required to be, and have been, notified as to the amounts paid to respondents and as to the amounts demanded but not allowed to respondents under the plan, as required by law. No employee has objected to or appealed the denial of any claim involving a respondent under the plan's informal procedures, and there is no such allegation in the complaints.

The effect of the decision appealed from — permitting direct action against the plan by a health provider — is to nullify ERISA's informal settlement procedures and to expose the nation's employers to unwarranted additional costs.

The natural reluctance of a health provider to sue his patient is lost entirely when he — or his bill collector — is permitted to use ERISA as his collection vehicle.

To permit him to do so would deprive the employer of his right under ERISA to informally resolve any dispute face to face with his employees. Any health provider who is determined to charge more than the plan allows could require his patient's employer to bear the time, cost and frustration of defending all claims asserted, regardless of merit, in federal or state courts. The law does not require the employer to labor under such a burden.

CONCLUSION

If the decision of the Illinois Supreme Court is permitted to stand, employers who wish to protect themselves from costly litigation with health providers will inevitably be motivated to amend their plans to prohibit the assignment of the right to reimbursement for medical care. This will have profound and undesirable consequences. Employees will be required to pay their own medical expenses and those of their dependents and await compensation from the plan, a substantial detriment and hardship to the very "participants" and "beneficiaries" whom Congress intended to protect.

Clear error was committed by the Illinois Supreme Court in authorizing suit under ERISA by parties never contemplated by Congress. The impact of this decision, if not corrected by this Court, will be felt far beyond the parties presently before the Court and will do mischief in the administration, formation, continuance, and growth of health benefit plans throughout the nation.

For the various reasons stated, this Court should grant certiorari.

Respectfully submitted,

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APPENDIX

APPENDIX

IN THE
SUPREME COURT OF ILLINOIS

No. 63702

T.J. Kennedy, et al,
Appellees,

vs.

Deere & Company,
Appellant.

Filed September 21, 1987

JUSTICE WARD delivered the opinion of the court:

The plaintiffs, T.J. Kennedy, Terry Burke, Michael Hurst, Stephen Miner and James Woods, who are chiropractors, filed actions in the circuit court of Rock Island County against the defendant, Deere & Company, to recover damages under the Employee Retirement Income Security Act of 1974 [29 U.S.C. sec. 1001 et seq. (1982)] (ERISA). The defendant moved to dismiss the suits, alleging that the plaintiffs lacked standing to sue under ERISA. After consolidating the suits, the circuit court granted the defendant's motion and dismissed the actions. The appellate court reversed (142 Ill.App.3d 781), and we allowed the defendant's petition for leave to appeal under Supreme Court Rule 314 [103 Ill.2d R. 315(a)].

In substantially similar complaints, the plaintiffs allege that they provided chiropractic services to several of the defendant's employees who are covered by its health and welfare plan (the plan) which is subject to the provisions of ERISA. [See 29 U.S.C. sec. 1002(1) (1982).] They allege that these employees

assigned to the plaintiffs their rights to benefits under the plan which here consist of the right to reimbursement for medical care. The complaints set out that the plaintiffs submitted claims to the plan for payment and that the trustees of the plan refused to honor certain of the assignments. When considering a motion to dismiss, all facts properly pleaded in a complaint and the exhibits will be taken as true in deciding whether to grant this motion. *State Bank v. A-Way, Inc.* (1986), 115 Ill.2d 401, 404; *Soules v. General Motors Corp.* (1980), 79 Ill.2d 282, 284.

The plaintiffs claim that they are entitled to recover under ERISA because of the defendant's failure to honor the assignments. The plaintiffs assert that they are "beneficiaries" as defined in section 2(8) of ERISA [29 U.S.C. sec. 1002(8) (1982)] and entitled to file an action under sections 502(a)(1)(B) and 502(e)(1) [29 U.S.C. secs. 1132(a)(1)(B), (e)(1) (1982)].

> Under section 502(a)(1)(B) of ERISA:
> "A civil action may be brought * * *
> (1) [B]y a participant or beneficiary * * *
>
> * * *
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights * * * under the terms of the plan * * *" [29 U.S.C. sec. 1132(a)(1)(B) (1982).]

ERISA defines a "participant" as:

> "[A]ny employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit." [29 U.S.C. sec. 1002(7) (1982).]

A "beneficiary" is defined as:

> "[A] person designed by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." [29 U.S.C. sec. 1002(8) (1982).]

Section 502(e)(1) provides that State and United States district courts shall have concurrent jurisdiction of actions brought under section 502(a)(1)(B).

Count I of the complaints alleges that the defendant violated section 540 of ERISA [29 U.S.C. sec. 1140 (1982)], in that, though the defendant made payments directly to certain other health care providers, it refused payment to the plaintiffs, claiming that as simply assignees, the plaintiffs were not beneficiaries. Section 540 provides:

> "It shall be unlawful for any person to * * * discriminate against a participant or beneficiary * * * for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan * * *." [29 U.S.C. sec. 1140 (1982).]

Count II asserts that the plaintiffs as "beneficiaries" are entitled to file an action based on assignments under section 502(a)(1)(B) to enforce their rights to benefits against the plan. The plaintiffs also claim attorney fees under section 502(g)(1) [29 U.S.C. sec. 1132(g)(1) (1982)].

The circuit court held that the plaintiffs lack standing to sue under ERISA on the ground that only "participants" or "beneficiaries" of a health benefit plan are entitled to bring an action under section 502(a)(1)(B) and that the plaintiffs are neither beneficiaries nor participants as those terms are defined in section 3(7) and (8) of ERISA. The appellate court reversed, holding that the plaintiffs, as assignees of a participants' right to receive benefits under the plan, are "beneficiaries" within section 3(8) of ERISA. Finding there was no restriction against the assignment of claims for benefits under a health care plan

covered by ERISA, the court concluded that "where an ERISA plan participant or beneficiary voluntarily elects in a signed writing to assign his rights to claim health insurance benefits to the provider of health care services, such assignee has standing to sue as the 'participant' or 'beneficiary' in whose shoes he stands for purposes of [section 502(a)(1)(B)]." 142 Ill.App.3d 781, 787.

The defendant, arguing that the appellate court erred, contends that although plan participants may "designate" a "beneficiary" who will then be entitled to benefits under the plan, a participant may designate only members of his family or other dependents. The defendant's position is that the express purpose of ERISA is to protect participants, their families and other dependents who are covered by a plan and is not to protect health care providers. It follows, the defendant says, only those intended to be protected under ERISA are entitled to bring an action under ERISA to recover benefits under a health benefit plan. Since health care providers, like the plaintiffs, are not within this limited class to be protected, the defendant argues, they cannot be designated by a participant to receive benefits under a plan.

The defendant contends further that even if a plan participant could assign his right to benefits under a health care plan to a health care provider, an assignment to a health care provider should not create en enforceable right to sue under ERISA. The defendants argue that allowing a simple assignee to bring an action under ERISA would encourage a flood of suits against employers and plan administrators. The defendant sees a deluge of actions by bill collectors, who under section 501(g)(1) of ERISA, could also be awarded attorney fees. It says that Congress did not intend the statute to be given so broad a construction that any assignee could sue under ERISA to obtain benefits under a health benefit plan and attorney fees as well. Permitting such suits, the defendant states, will discourage employers from establishing health benefit plans.

From the statute's preamble it is clear that the principal concern of Congress in enacting ERISA was "to protect * * * the interests of participants in employee benefit plans and their beneficiaries." [29 U.S.C. sec. 1001(b) (1982).] Congress did not proscribe any qualifications for a beneficiary. Section 206(d) of ERISA [29 U.S.C. sec. 1056(d) (1982)] prohibits the assignment of pension benefits, but there is nothing in ERISA or in the legislative history showing a congressional intent to prohibit assignments of health care benefits or to limit the class of persons a participant is permitted to designate to receive benefits under a health benefit plan. As ERISA as a whole is "comprehensive and reticulated" [*Nachman Corp. v. Pension Benefit Guaranty Corp.* (1980), 446 U.S. 359, 361, 64 L.Ed.2d 354, 358, 100 S.Ct. 1723, 1726), and "[t]he assumption of inadvertent omission is * * * especially suspect" [*Massachusetts Mutual Life Insurance Co. v. Russell* (1985), 473 U.S. 123, 146, 87 L.Ed.2d 96, 106, 105 S.Ct. 3085, 3093], there can be no assumption that Congress intended to restrict the class of beneficiaries.

Permitting assignments of health care benefits to health care providers is consistent with the intent of Congress in providing under ERISA for health and welfare benefit plans. It is to be observed that under the defendant's plan the "benefits" the participant is entitled to are limited to payments for medical care under the plan. The defendant is not obligated contractually to provide the medical care but only to pay for it. The participant is free to select the health care provider he wishes, and if the charges are reasonable, the plan will provide payment to the participant as reimbursement. The participant determines the health care provider that will receive the benefits to which he is entitled under the plan. Indeed, the defendant even has provided its employees with forms that allow the participants to authorize the plan to make payments directly to the health care provider.

The Circuit Court of Appeals for the Ninth Circuit held, and correctly, we consider, in *Misic v. Building Service Employees*

Health & Welfare Trust (9th Cir. 1986), 789 F.2d 1374, that a participant in a health benefit plan may properly make assignments in favor of health care providers. The court stated:

> "Health and welfare benefit trust funds are designed to finance health care. Assignment of trust monies to health care providers results in precisely the benefit the trust is designed to provide and the statute is designed to protect. Such assignments also protect beneficiaries by making it unnecessary for health care providers to evaluate the solvency of patients before commencing medical treatment, and by eliminating the necessity for beneficiares to pay potentially large medical bills and await compensation from the plan. Moreover, assignments permit a trust fund to obtain improved benefits for beneficiaries by bargaining with health care providers for better coverage and lower rates." 789 F.2d 1374, 1377.

If Congress intended to permit a participant to assign his health care benefits, it seems undeniable that Congress also must have intended to permit the assignee to enforce his right to benefits under ERISA. Indeed, an action under ERISA appears to be the only way in which an assignee could enforce his claim to benefits under a plan, because section 514(a) of ERISA [29 U.S.C. sec. 1144(a) (1982)] would prohibit an assignee from acting under State law to establish a legal claim to benefits under a plan. Section 514(a) provides that "the provisions of this subchapter * * * shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan * * *" If assignees are barred from bringing an action under ERISA they would necessarily be without a remedy.

The *Misic* court not only made clear that the right to health care benefits could be assigned under ERISA but held too that an assignee may enforce his right to benefits. There the defendant-employer had established a health and welfare benefit plan providing medical and dental benefits. The plan

provided that it would reimburse participants for a portion of their dental care expenses. The plaintiff, a dentist, provided services to participants of the plan, who in turn assigned to the plaintiff their right to reimbursement from the fund. The plaintiff sued the employer under ERISA to recover through the assignments.

The court held first that Congress did not intend to prohibit a participant of a health benefit plan from designating a health care provider as a beneficiary. The court then stated that in interpreting ERISA's provisions, Federal common law applied, and that under Federal common law an assignee of a valid assignment has standing to sue in the place of the assignor. [*Misic v. Building Service Employees Health & Welfare Trust* (9th Cir. 1986), 789 F.2d 1374, 1378 & n.4.] The court concluded, there being no express prohibition against assignments in ERISA, there was no reason to bar the plaintiff from suing under ERISA as an assignee of his patient's right to benefits under the plan.

We hold that when an employer-participant assigns his right to benefits under the plan to the health care provider, the provider can bring an action under ERISA to enforce that right.

For the reasons given, the judgment of the appellate court is affirmed and the cause is remanded to the circuit court of Rock Island County for further proceedings consistent with this opinion.

Affirmed and remanded.

JUSTICE CUNNINGHAM took no part in the consideration or decision of this case.

T.J. Kennedy, D.C.; Terry L. Burke d/b/a Burke Chiropractic Clinic; Michael H.W. Hurst d/b/a Hurst Chiropractic Center; Stephen Miner, D.C. d/b/a Miner Chiropractic Clinic; and James P. Woods, D.C., Plaintiffs-Appellants,

v.

Deere & Company, Defendant-Appellee.

No. 3-85-0247.

Appellate Court of Illinois, Third District.

April 3, 1986.

Rehearing Denied May 19, 1986.

Chiropractors brought action to recover unpaid charges for services rendered to patients who were participants or beneficiaries of defendant employer's health insurance plan. The 14th Judicial Circuit Court, Rock Island County, David DeDoncker, J., dismissed action on standing grounds, and chiropractors appealed. The Appellate Court, Barry, J., held that chiropractors, as assignees of plan participants' rights to claim health insurance benefits, had standing to sue for payments due under the plan governed by ERISA.

Reversed and remanded.

1. Assignments 12

Lacking any statutory prohibition, right to receive monies due or to become due under existing contract may be assigned, though contract itself may be unassignable.

2. Assignments 121

Assignee for collection may sue as real party in interest.

Labor Relations 139

Chiropractors, as written assignees of their patients' claims for benefits under employer's health care plan governed by ERISA, had standing to bring action against employer to recover unpaid charges. Employee Retirement Income Security Act of 1974, sec. 502(a)(1)(B), 29 U.S.C.A. sec. 1132(a)(1)(B).

4. Pensions 139

Where ERISA plan participant or benficiary voluntarily elects in signed writing to assign his right to claim health insurance benefits to provider of health care services, that assignee has standing to sue as "participant" or "beneficiary" to recover payments due under plan. Employee Retirement Income Security Act of 1974, sec. 502(a)(1)(B), 29 U.S.C.A. sec. 1132(a)(1)(B).

Francis Van Hooreweghe, Van Hooreweghe, Fackel, & Thuline, Moline, for plaintiffs-appellants.

Hubbard B. Neighbour and Robert A. Latham, III, Bozeman, Neighbour, Patton & Noe, Moline, for defendant-appellee.

Justice BARRY delivered the opinion of the court.

Plaintiffs are chiropractors who sued in the circuit court of Rock Island County to recover unpaid charges for services rendered to patients who are participants or beneficiaries of defendant Deere and Company's health insurance plan. Subsequent to the initial filing by plaintiff Kennedy, several similar complaints were brought by other providers of chiropractic services. The suits were consolidated in the circuit court of Rock Island and will be referred to in the singular for purposes of this disposition. After several amendments, the suit emerged as a two-count complaint alleging breach of contract and discrimination in payments, and claiming benefits payable pur-

suant to section 1132(e)(1) of the Federal Employee Retirement Income and Security Act ("ERISA" or "the Act") [29 U.S.C. sec. 1132(e)(1)].

Plaintiffs allege that they are assignees of their patients' claims for benefits under defendant's health care plan which is regulated by ERISA and that in each instance the patient has also signed a claim form, provided by defendant for its employees' convenience, authorizing payment directly to the health care provider. On motion of defendant, and relying on the holding and reasoning of *Cameron Manor v. United Mine Workers of America* (W.D.Penn. 1983), 575 F.Supp. 1243, the trial court dismissed plaintiff's complaint on the ground that plaintiffs lacked standing to sue under section 1132(a)(1)(B) of the Act. That section, in pertinent part, provides:

> "(a) A civil action may be brought — (a) by a participant or beneficiary —
>
> . . . . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. sec. 1132(a)(1)(B).

The issue presented for our review is whether the execution of forms authorizing the employer to pay benefits directly to a provider and purporting to transfer the right to claim health benefits under an employee's health care plan covered by ERISA confers on the provider the right to sue pursuant to section 1132(a)(1)(B) of the Act. For purposes of our review, all facts well-pleaded in plaintiff's complaint are regarded as true and admitted. *Sturm v. Block* (3d Dist. 1979), 72 Ill.App.3d 306, 28 Ill.Dec. 553, 390 N.E.2d 912.

Resolution of the issue before us begins with our consideration of the *Cameron Manor* opinion. There, the federal district court ruled that plaintiff, a nursing care facility, was precluded

from bringing suit under ERISA because it was neither a "participant" nor a "beneficiary" of an employee benefit plan. The court considered the plaintiff provider's contention that it was a "beneficiary" entitled to file a civil suit under section 1132(a)(1)(B). The term "beneficiary" is defined in section 1002(8) of the Act to mean "a person designated by a participant or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." [575 F.Supp. at 1245 (quoting 29 U.S.C. 1001(8)).] The court then explained that " '[b]eneficiary' in the context of the various provisions of ERISA carries the connotation of a person, other than the employee-participant, who is covered by the plan's provisions — e.g., a spouse or dependent. Furthermore, the act of 'designation' would appear to be such formal election as that contained in 29 U.S.C. sec. 1055, rather than the patient's choice of facility." The court continued, "[T]he declared purpose of the Act is to protect and educate those persons covered by such plans, and there is no indication that Congress intended by this statute to insure that health care facilities be paid. While Plaintiff may indeed be entitled to a 'benefit' through operation of the plan — i.e., payment for services — we conclude that the term as employed in the statute does not permit of a construction broad enough to include a provider of health service to participants. See, *Hibernia Bank v. International Brotherhood of Teamsters,* 411 F.Supp. 478 (N.D.Cal. 1976); *National Bank of North America v. Local 553 Pension Fund,* 463 F.Supp. 636 (E.D. N.Y. 1978)." 575 F.Supp. at 1245-46.

Defendant here urges a broad reading of *Cameron Manor* to preclude all suits by providers, at least to the extent that such providers are selected by the employee, rather than by the employer. In so arguing, defendant acknowledges that, unlike the plaintiffs in this case, plaintiff in *Cameron Manor* did not allege that it was an assignee for purposes of claiming benefits payable under the employer's health care plan or that it had written authorization to receive payments directly from the

plan. Defendant attempts to dismiss this distinguishing factor by characterizing the execution of assignment/authorization forms as a "fleeting and informal act, . . . simply a matter of 'where do I sign?' " Plaintiffs, on the other hand, maintain that this distinction is all important, and that defendant's and the trial court's reliance on *Cameron Manor* is, therefore, misplaced.

The two forms completed by the employees, which plaintiffs here contend give them standing to sue as beneficiaries or participants under defendant's plan, read as follows:

> "For value received, I hereby assign to (*doctor*) the the extent of my bill for health care services, any and all claims which I may have:
>
> (a) For benefits provided under any policy of insurance or other health care plan . . .";
>
> and
>
> "AUTHORIZATION TO PAY (Employee: sign below only if payment is to be made directly to physician)
>
> I hereby authorize payment of surgical and/or medical benefits, if any, otherwise payable to me, directly to the physician-whose signature appears below."

The first form above, the assignment form, was prepared in each instance by plaintiffs; and the latter (authorization to pay) form, by defendant Deere & Co.

In this appeal, defendant does not attack the validity of the forms as such, but urges that they be disregarded for purposes of determining plaintiffs' standing to sue under ERISA because they do not confer on the providers the full panoply of rights as "beneficiaries" or plan "participants." Defendant's arguement ignores the well-established principles of assignments, their creation and their legal consequences.

> "An assignment * * * is the transfer of some identifiable property, claim or right from the assignor to the assignee. The parties must intend to effectuate an assignment at the time of the transfer although no particular language or procedure is necessary. (Citation omitted.) If a valid assignment is effected, the assignee acquires all of the interest of the assignor in the property that is transferred. The assignee, it has been often said, is placed 'in the shoes' of the assignor. *Chicago in Trust for Use of Schools v. Fischer,* 52 Ill.App.2d 55, 61, 201 N.E.2d 660." *Buck v. Illinois National Bank & Trust Co.* (4th Dist. 1967), 79 Ill.App.2d 101, 106, 223 N.E.2d 167, 169.

[1,2] Lacking any statutory prohibition, the right to receive moneys due or to become due under an existing contract may be assigned though the contract itself may be unassignable. [*DuPont DeBie v. Vredenburgh* (4th Cir. 1974), 490 F.2d 1057]. Under federal common law, no less than under the law of this state, an assignee for collection may sue as the real party in interest. *Staggers v. Otto Gerdau Co.* (2nd Cir. 1966), 359 F.2d 292 [citing *Rosenblum v. Dingfelder* (2nd Cir. 1940), 111 F.2d 406].

[3] Defendant has not directed our attention to any anti-assignment provisions in the defendant's health care plan or in the welfare benefits provisions of ERISA. [But *c.f. Helmsley-Spear Inc. v. Winter* (Sup.1979), 101 Misc.2d 17, 420 N.Y.S.2d 599, (anti-assignment or "spendthrift" clause was contained in employer's profit-sharing plan covered under ERISA); and 29 U.S.C. sec. 1056(d) (which prohibits, with certain exceptions, assignment of benefits under a pension plan covered by ERISA).]

Lacking any restriction on the assignment of claims for benefits under a health care plan covered by ERISA, we can perceive of no rational basis upon which to deny these plaintiffs standing to sue under section 1132(e) for benefits payable as

assignees of the plan "participants" or "beneficiaries" in whose shoes they stand.

Although not cited by either party to this suit, we find support for our holding today in a somewhat analogous situation addressed by a Texas court of appeals. [*General Dynamics Corp. v. Harris* (Tex.Civ.App. 1979), 581 S.W.2d 200.] The Texas divorce court, pursuant to that state's community property law, awarded Mrs. Harris her husband's vested retirement benefits accrued during their marriage and attributable to his employment with General Dynamics. The court directed Mr. Harris to execute a release of such benefits in favor of Mrs. Harris. It appears that Mr. Harris failed to comply with the order. General Dynamics also refused Mrs. Harris' request to pay the benefits to her pursuant to the divorce decree, and she accordingly brought suit against her former husband's employer. General Dynamics' retirement plan was subject to ERISA. In its defense, General Dynamics took the position that the divorce decree awarding pension benefits to Mrs. Harris violated the inalienability terms of the plan, and that Mrs. Harris' suit should be abated until Mr. Harris was joined as a party plaintiff. The trial court granted judgment for Mrs. Harris. On appeal, General Dynamics contended that Mrs. Harris had no standing to sue under section 1121(a)(1)(B) because she was neither a beneficiary nor a participant under the plan. The court disagreed. Adopting the reasoning of the court in *Stone v. Stone* (N.D.Cal.1978), 450 F.Supp. 919, the court concluded that neither the ERISA preemption clause nor the anti-assignment clause affecting pensions under ERISA [29 U.S.C. sec. 1056(d)] prevented a state court from awarding in a divorce decree vested retirement pension benefits to a non-employee spouse. The court held that "if the transfer of benefits was proper, then the cause of action set forth in sec. 1132(a)(1)(B) for recovery of the benefits was also transferred." *Harris,* 581 S.W.2d at 312.

Unlike plaintiff in *Harris,* the plaintiffs in the present case, as aforesaid, need not overcome anti-assignment provisions. Fur-

thermore, unlike plaintiff in *Harris,* who asserted her standing to sue under ERISA on the basis of an involuntary transfer of benefits ordered without the employer's participation or acquiescence, plaintiffs here ground their right to bring suit on the basis of written, voluntary assignments and authorization-to-pay forms — the latter of which was provided by defendant for the convenience of its employees and, presumably, for the convenience of providers of health care services and perhaps themselves as well.

Defendant's challenge to the assignment/authorization-to-pay forms on grounds that they are not "formal designations" is not well taken. In *Cameron Manor,* the court contrasted the "formality" of an act of beneficiary "designation" to plaintiff's theory that by choosing to be treated at the plaintiff facility, defendant's employees "tacitly" transferred their right to claim benefits due under defendant's health care plan. Under the *Cameron Manor* fact pattern there was no showing of any purposeful act performed by the plan participants or beneficiaries to transfer their right to claim benefits due for the services rendered by the provider. In contrast to *Cameron Manor* it is uncontested that plaintiffs here allege "formal," purposeful acts of executing two forms specifically drafted for the purpose of transferring to plaintiffs the right to claim benefits due and to receive them directly from the defendant's health care plan. No greater "formality" is required.

We have reviewed all of defendant's other contentions resisting the conclusion that these plaintiffs have standing to sue under section 1121(a)(1)(B), and we find them without merit. The assignment/authorization-to-pay forms that were executed herein are not affected by ERISA preemption. The cases cited by defendant in which fiduciary institutions, employers, judgment creditors and non-employee spouses were denied standing to sue as "beneficiaries" or plan "participants" under ERISA are not affected by our ruling today, inasmuch as it does not appear that voluntary written assignments were executed in any

such instance. See, *Hibernia Bank v. International Brotherhood of Teamsters,* (N.D.Cal. 1976), 411 F.Supp. 478, (bank serving union trustees of pension funds denied standing to sue); *Tuvia Convalescent Center Inc. v. Nat'l Union of Hospital and Health Care Employers, etc.* (2d Cir. 1983), 717 F.2d 726 (employer denied standing to sue); *National Bank of America v. Local 553 Pension Fund of the International Brotherhood of Teamsters and Chauffeurs* (E.D.N.Y. 1978), 463 F.Supp. 636 (judgment creditor denied standing); and *Lerra v. Monsanto Co.* (D.Mass. 1981), 521 F.Supp. 1257 (non-employee spouse denied standing to sue).

[4] In sum, we hold that where an ERISA plan participant or beneficiary voluntarily elects in a signed writing to assign his rights to claim health insurance benefits to the provider of health care services, such assignee has standing to sue as the "participant" or "beneficiary" in whose shoes he stands for purposes of section 1132(a)(1)(B). By our holding, we believe that we do no offense to the express purpose of the Act — to protect and to educate persons covered by an ERISA plan. Insofar as the participants and beneficiaries are shielded from the costly and burdensome task of pursuing their individual remedies from the employer in question, our holding promotes the legislatively-stated goal of protection.

Having disposed of the only issue properly presented for our review, we remand this case to the circuit court of Rock Island County for further proceedings.

Reversed and remanded.

HEIPLE, P.J., and WOMBACHER, J., concur.

IN THE CIRCUIT COURT OF THE
FOURTEENTH JUDICIAL CIRCUIT
ROCK ISLAND COUNTY, ILLINOIS
COUNTY DIVISION

CONSOLIDATED
No. 83 L 230

T.J. Kennedy, D.C.; Terry L. Burke
d/b/a Burke Chiropractic Clinic;
Michael H.W. Hurst d/b/a Hurst Chiropractic
Center; Stephen Miner, D.C. d/b/a Miner
Chiropractic Clinic; Harlow E. Wells, D.C.
d/b/a Wells Chiropractic Clinic; and
James P. Woods, D.C.,
Plaintiffs,

vs.

Deere & Company,
Defendant.

ORDER

FILED
March 19, 1985

The motion of defendant to dismiss the Third Amended Complaints of plaintiffs Kennedy, Burke and Hurst, to dismiss the Amended Complaint of plaintiff Miner, and to dismiss the Second Amended Complaint of plaintiff Woods, comes on for hearing, and the court having considered said complaints, the memoranda of law submitted by the parties and the arguments of counsel, and now being fully advised, finds that the plaintiffs lack standing to sue under ERISA and accordingly, it is ORDERED

1. That each of said complaints be, and they are hereby dismissed with prejudice, and the defendant is awarded judgment for its costs.

2. In dismissing said complaints, the court relies primarily upon the decision and reasoning of the United States District Court for the Western District of Pennsylvania in *Cameron Manor, Inc. v. United Mine Workers* (1983), 575 F.Supp. 1243.

3. In view of my finding that plaintiffs lack standing to sue, it is unnecessary to rule on the other issues raised in said motion.

ENTER this 19th day of March, 1985.

/s/ David DeDoncker

Chief Judge

ERISA sec. 3(8) [29 U.S.C. 1002(8)]:

The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

ERISA sec. 101(a) [29 U.S.C. 1021(a)]:

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan —

(1) a summary plan description described in section 1022(a)(1) of this title; and

(2) the information described in section 1024(b)(3) and 1025(a) and (c) of this title.

ERISA sec. 104(b)(3) [29 U.S.C. 1024(b)(3)]:

Within 210 days after the close of the fiscal year of the plan, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, a copy of the statements and schedules, for such fiscal year, described in subparagraphs (A) and (B) of section 1023(b)(3) of this title and such other material as is necessary to fairly summarize the latest annual report.

ERISA sec. 105(a) [29 U.S.C. 1025(a)]:

Each administrator of an employee pension benefit plan shall furnish to any plan participant or beneficiary who so requests in writing, a statement indicating, on the basis of the latest available information —

(1) the total benefits accrued, and

(2) the nonforfeitable pension benefits, if any, which have accrued, or the earliest day on which benefits will become nonforfeitable.

ERISA sec. 206(d) [29 U.S.C. 1056(d)]:

Each pension plan shall provide that benefits provided under the plan may not be assigned or alienated.

ERISA sec. 404(a)(1) [29 U.S.C. 1104(a)(1)]:

Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

ERISA sec. 502(a) [29 U.S.C. 1132(a)]:

A civil action may be brought —

(1) by a participant or benficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or the clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plans;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

ERISA sec. 502(e)(1) [29 U.S.C. 1132(e)(1)]:

Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary,

or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

ERISA sec. 505 (29 U.S.C. 1135):

Subject to subchapter II of this chapter and section 1029 of this title, the Secretary may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter. Among other things, such regulations may define accounting, technical and trade terms used in such provisions; may prescribe forms; and may provide for the keeping of books and records, and for the inspection of such books and records [subject to section 1134(a) and (b) of this title].

ERISA sec. 514(a) [29 U.S.C. 1144(a)]:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Supreme Court, U.S.
FILED
JAN 15 1988
JOSEPH F. SPANIOL, JR.
CLERK

No. 87-1037

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

DEERE & COMPANY,
Petitioner,

vs.

T. J. KENNEDY, *et al.*,
Respondents.

RESPONSE TO PETITION FOR A WRIT OF CERTIORARI FROM THE ILLINOIS SUPREME COURT

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QUESTION PRESENTED FOR REVIEW

Contrary to the representation of Petitioner, the only issue presented for review is: Does an assignee designated by a participant under an employee health care plan have standing to sue the plan administrator directly for those benefits under ERISA?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings were the petitioner, Deere & Company, and the Respondents, T. J. Kennedy, D.C.; Terry L. Burke d/b/a Burke Chiropractic Clinic; Michael H. W. Hurst d/b/a Hurst Chiropractic Center; Stephen Miner, D.C. d/b/a Miner Chiropractic Clinic; and James P. Woods, D.C. In the trial court, the suit of Harlow E. Wells, D.C. had been consolidated with the suits of the other respondents named above, but Wells voluntarily dismissed his suit against the petitioner on November 16, 1984.

The subsidiaries of Deere & Company as listed by the petitioner, while impressive, are not parties to this action.

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Respondents agree to the Statutes as submitted by the Petitioner herein.

STATUTES INVOLVED

Sec. 502 (a)(1)(B) of ERISA [29 U.S.C. sec. 1132(a)(1)(B)]:

A civil action may be brought —

(1) by a participant or beneficiary * * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan * * *

Title 29 U.S.C., §1002(8):

(8) the term "beneficiary" means *a person designated by a participant,* or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

No. 87-1037

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OPINIONS BELOW

Respondents agree to the Opinions Below as submitted by the Petitioner herein.

JURISDICTION

Respondents agree to the Jurisdiction as stated by the Petitioner herein.

STATEMENT OF THE CASE

Respondents are required to correct certain blatant misstatements of fact in this portion of Petitioner's submission.

This *is* a suit charging in Count I that Petitioner violates 29 U.S.C. §1140, by paying certain health care providers, e.g. physical therapists, for services identical to that provided by respondents; and then refusing to pay respondents.

This *is* a claim that respondents are entitled to be paid for outpatient physical therapy under a provision in the plan that states:

> "Outpatient physical therapy benefits will be payable for services performed for a period of 60 treatment days when prescribed by a physician for a specified condition resulting from disease or injury or prescribed immediately following surgery related to the condition and when the physical therapy is performed in a nursing home or *other facilities such as rehabilitation centers having comprehensive physical therapy facilities.*" (emphasis supplied)

This dispute is *not* about the payment of reasonable and customary costs of service.

The Deere & Company plan does *not* provide for payment of "reasonable and customary cost of services given by chiropractors;" but does provide for payment of physical therapy services which Deere has refused to do for respondents.

This dispute is *not* about "chiropractors (who) assert that the value of their services . . . far exceeded the amounts allowed under the plan.

It is *not* a "sharp disagreement between petitioner and respondents as to whether respondents were overcharging for their services."

We commend the Petition to you with this correction of the nature of the dispute. One wonders why the true nature of the conflict needs obfuscation?

REASONS FOR DENYING THE WRIT

THE DECISION OF THE ILLINOIS SUPREME COURT FOLLOWS THE PLAIN LANGUAGE OF ERISA.

THE STATUTE SPECIFICALLY PROVIDES THAT A "PARTICIPANT" MAY "DESIGNATE" A "BENEFICIARY.". BOTH THE "PARTICIPANT" AND THE "BENEFICIARY" MAY SUE TO COLLECT BENEFITS IN FEDERAL OR STATE COURT.

NO CONFLICTS EXISTS IN THE EXISTING APPELLATE OPINIONS. ALL ARE IN ACCORD SUPPORTING STANDING TO SUE.

NO INTERPRETATION OF THE PLAIN LANGUAGE OF THE STATUTE IS REQUIRED. NO AMBIGUITY NEED BE RESOLVED. NO EXPANSION OF UNINTENDED REMEDIES EXISTS.

A DECISION RECOGNIZING THE EXPRESS LANGUAGE OF THE STATUTE DOES NOT POSE A FEDERAL QUESTION OF SUCH IMPORT AS TO MERIT THE INTERVENTION OF THIS AUGUST COURT.

A DECISION THAT RESULTS IN THE EMPLOYEE BEING GRANTED PRECISELY THE BENEFIT THE TRUST IS DESIGNED TO PROVIDE SHOULD NOT BE QUESTIONED.

NO FLOOD OF LITIGATION HAS RESULTED. ERISA'S LANGUAGE HAS BEEN THE SAME SINCE 1974, AND NO SUCH "FLOOD" HAS INUNDATED THE COURTS. IN FACT, THE ONLY TIME THERE WILL BE ANY LITIGATION IS WHEN A PLAN REFUSES TO PAY AS AGREED. THIS SUIT IS *NOT* ABOUT OVERCHARGES. IT IS ABOUT DISCRIMINATION IN THE PAYMENTS FOR PHYSICAL THERAPY IN VIOLATION OF THE PLAN PROVISIONS AND ERISA.

ERISA states:

Title 29, U.S.C., §1002(8):

> "(8) the term "beneficiary" means *a person designated by a participant,* or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."

Title 29, U.S.C. §1132(a)(1)(B):

> "Persons empowered to bring a civil action. A civil action may be brought —
>
> (1) By a participant or *beneficiary* —
>
> (A) for the relief provided for in subsection (c) of this section or,
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . ."

A federal appellate court, and now the Supreme Court of Illinois, following the express language of the statute, have held that plaintiffs have standing to pursue their claims.

No conflict of decisions exists. All appellate decisions on point, federal and state, are in accord. Thus, Supreme Court rule 17.1(a) and (b) are no basis to grant the Petition in this cause *Misic v. Building Services Employees Health & Welfare Trust,* 789 F.2d 1374 (9th Cir. 1986; *Kennedy, et al v. Deere & Company,* 118 Ill.2d 69, 514 NE2d 171 (1987)

Rule 17.1(c) remains. Petitioner states that because of the broad far-reaching effect of this decision, there must be then an important question of federal law which this court should settle.

The provisions of ERISA have been the same since 1974. The "flood" of litigation which petitioner predicts has failed to materialize in fourteen years.

It stretches the imagination to think that Congress failed to consider this issue in the drafting process.

> "The assumption of inadvertant omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute'." *Massachusetts Mutual Life Insurance Company v. Russell,* 105 S.Ct. 3085 (1985).

Congress outlawed assignment of pension benefits and not health care benefits. Clearly, the subject of assignment was considered.

In point of fact, the only time litigation will arise is when the plan administrator fails to pay as agreed. We suggest that is exactly when litigation is proper, and the employee will be the one protected as ERISA seeks to do.

As stated, this dispute is *not* about overcharging.

It is about a plan administrator refusing to pay as agreed.

Count I alleges that Defendant violated 29 U.S.C. §1140. That section provides:

> "It shall be unlawful for any person to . . . discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan . . ."

Plaintiffs allege that Defendant pays medical doctors, physical therapists, hospitals and other health care providers at different and higher rates, than it will pay Plaintiffs for identical services.

Count II deals with payment for outpatient physical therapy. The plan states:

> "Outpatient physical therapy benefits will be payable for services performed for a period of 60 treatment days when prescribed by a physician for a specified condition resulting from disease or injury or prescribed immediately following surgery related to the condition and when the physical therapy is performed in a nursing home or *other facilities such as rehabilitation centers having comprehensive physical therapy facilities.*" (emphasis supplied)

Plaintiffs allege they are entitled to be paid for services provided pursuant to this section, and Defendant has refused to do so.

This court, faced with the many weighty matters before it, need not concern itself with the few occasions when a plan administrator attempts to arbitrarily ignore its obligations to the employees it is charged to protect. The remedy is available as provided by Congress. No confusion needing your intervention exists. No damage to the detriment of the protected employee will result, and the administrator will be called upon to respond only when it violates its fiduciary duty to the employee.

CONCLUSION

There certainly is no conflict between the decision sought to be reviewed and a decision of this Court, or any other court.

No need to exercise supervisory authority exists; and despite the cries of doom and gloom put forth by the petitioner, one must remember that the sole issue that has been decided in this matter is that a participant in a health care plan can assign his right to payment to a health care provider. Then, on the basis of that assignment, pursuant to the time-honored rules in regard to same, the provider may bring an action to enforce his right to payment.

No cause of action was "created" by this decision. The cause of action was "created," if you will, by the express language of ERISA which:

> (1) states that a participant may designate a beneficiary who is or may be one who will receive a benefit under the plan, and
>
> (2) grants a beneficiary the right to sue to obtain his benefits under the plan and
>
> (3) grants concurrent jurisdiction in the State court to do so.

This language, when reviewed in light of the general law of assignments, makes the decision inescapable.

There, further, is no evidence in the record that would indicate any deleterious effect upon employers or their health care plans. All that has been decided here is that an employer who sets up a contractual arrangement allowing the assignment of the right to payment may expect that the assignee will seek to enforce the assignment. Thus, the assignee will not be without remedy.

Likewise, there is no evidence to support petitioner's claim of a "flood of litigation." Should such a "flood" result, which is unlikely, it could come about for only two reasons:

(1) The employers are not paying according to the contractual provisions of their plan; thus, *they should be called to task*; or

(2) Plaintiffs would be filing actions that could be sanctioned under Codes of Civil Procedure. Such sanction should be a sufficient deterrent to such activity.

Further, this Court in the past has never been intimidated by such a "flood of litigation" argument. One remembers well the response to such allegations that states: if the rights of employees are being ignored or willfully violated, and a "flood of litigation" be necessary to restore and protect those rights — so be it!

Respectfully submitted,

T.J. Kennedy, D.C.;
Terry L. Burke d/b/a Burke Chiropractic Clinic;
Michael H.W. Hurst d/b/a Hurst Chiropractic Center;
Stephen Miner, D.C. d/b/a Miner Chiropractic Clinic; and
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